ATTITUDES OF THE COORDINATING COUNCIL ON MEDICAL EDUCATION TOWARD PHYSICIAN MANPOWER*

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THE Coordinating Council on Medical Education (CCME) is a relatively new organization that was established through the joint efforts of the American Board of Medical Specialties (ABMS), the American Hospital Association (AHA), the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), and the Council of Medical Specialty Societies (CMSS). The first overt suggestion that such an agency be established was contained in one of the recommendations of the report of the Citizens Commission on Graduate Medical Education published in 1966.[1] It suggested that a commission on graduate medical education be formed by the board of trustees of the AMA and that membership consist of nominees recommended by several professional organizations.

This proposal was discussed for six years by many different agencies having some responsibility for graduate medical education, especially in the areas of certification and accreditation. There was an obvious reluctance by all agencies, but prinicpally by the specialty boards and societies, to assign a responsibility of this magnitude to a single agency.

The trustees of the AMA judiciously permitted the discussion to continue. In 1971, however, the ABMS passed a resolution to establish a Liaison Committee on Graduate Medical Education (LCGME) to function as a central accrediting agency for programs of graduate medical education. After numerous planning conferences, representatives of the ABMS, AHA, AMA, AAMC, and CMSS met in Washington on January 25,

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1972, and agreed to form the LCGME. To provide some overview of the accreditation mechanisms for all of medical education it was agreed at the same conference to establish the CCME. The LCME, with representation from the AAMC and AMA, had existed since 1942 with the authority to accredit medical schools in the United States. At the conference it was anticipated that liaison committees on continuing medical education and allied health education would be formed in the future. A Liaison Committee on Continuing Medical Education recently has been formed.

The CCME was established with equal representation from the five parent agencies as well as a representative from the U.S. Department of Health, Education, and Welfare (DHEW) and a public member. It was to oversee and coordinate the accrediting activities of the liaison committees and to be a forum for the development of national policies that would have an impact on all aspects of medical education. All such policies require the approval of the five parent organizations.

The first meeting of the LCGME was held in December 1972. A resolution was adopted unanimously requesting the CCME to assume the responsibility for studying and analyzing the problem of physician manpower in the United States. The resolution was transmitted to the CCME and at its first meeting in January 1973 it assumed this reponsibility. A committee on physician distribution was appointed with CCME members of the five parent bodies and a representative of DHEW.

This committee's early deliberations determined that no constructive assessment of the problem of specialty and geographic distribution of physicians could be addressed until an analysis of primary-care physicians and foreign medical graduates (FMGs) was completed. The subject of primary-care physicians was studied because there appeared to be some urgency for organized medicine to adopt a posture on primary care. The subject of FMGs was explored because of concern about the United States becoming dependent upon FMGs and the fact that no projections of the need for physicians could be made without a knowledge of the anticipated influx of FMGs.

The primary-care physician was defined by the committee as "a physician (or group of physicians) who establishes a relationship with an individual or a family for which he provides continuing surveillance of their health care needs, comprehensive care for the acute and chronic disorders which he is qualified to care for, and access to the health care delivery system for those disorders requiring the services of other specialists."[2]

It was recognized that many different types of physicians meet this definition. The newly formed specialty of family practice, as well as general internal medicine and general pediatrics, probably are identified most closely with physicians who conform to the definition and who are educated for such services. Medical and pediatric specialists such as cardiologists, gastroenterologists, and nephrologists, however, also assume a continuing responsibility for the comprehensive care of some patients, especially those with chronic disease. Obstetricians provide a considerable amount of care within this definition for women of child-bearing age. Psychiatrists and several surgical specialists such as orthopedists also are involved in primary care. The total amount of primary care provided by restricted specialists is unknown, although various estimates have been made. Studies are in progress to determine what proportion of the professional services provided by specialists is primary care. Whatever information ultimately becomes available on this subject will not change the attitudes of the public concerning the difficulty of obtaining the continuing services of a physician who can manage a high proportion of the complaints for which individuals seek medical service.

Between 1965 and 1972 there was an 8.4% reduction in the total number of physicians related to general and family practice, internal medicine, and pediatrics. Both internal medicine and pediatrics increased during this period; the over-all reduction was the result of the progressive attrition rate of general practitioners. During this same period there were increments of 19.6% in the number of surgical specialists and of 33.6% in the number of other specialists such as radiologists and pathologists.

The committee recognized that any desired change in the specialty distribution of physicians had to start in schools of medicine when the majority of career choices are made, at least for the major clinical categories. Since primary-care specialists such as general practitioners, general internists, and pediatricians essentially had lost their visibility in the environments of medical schools and many university hospitals, the most important recommendation in the committee's report (which was endorsed by the CCME and the five parent organizations) was that "As a national goal, schools of medicine should be encouraged to accept voluntarily a responsibility for providing an appropriate environment that will motivate students to select careers related to the teaching and practice of primary care. An initial target of having 50% of graduating medical students choose careers as primary care specialists appears reasonable."[3]

Although many changes in medical schools were already taking place as a result of students' incentives and the pressures of state legislatures and public opinion, the published report of the CCME on *The Primary Care Physician*[4] represents the policy of voluntary medicine because of the wide-ranging responsibilities of the constituents of the five parent organizations of the CCME.

Additional recommendations were made by the committee concerning the role of family medicine, internal medicine, and pediatrics in schools of medicine and their affiliated hospitals. The report also suggested that "the boards of Internal Medicine and Pediatrics can exert considerable influence upon the attainment of an appropriate balance between generalists and subspecialists if they reexamine their requirements for admission to their certifying examinations so that the educational programs and careers of internists and pediatricians interested in primary care will have at least the same professional prestige as the subspecialty categories of internal medicine and pediatrics."[5] The American Board of Internal Medicine has changed its requirements so that all internists will be required to have complete training, three years, in general internal medicine, whether they subsequently proceed with a subspecialty fellowship or not.

Eighty-six of the 114 medical schools in the United States now have established departments or administrative units of family medicine. In family practice 261 residency programs have been approved and 93 of these are in university-affiliated hospitals. They provide for 1,684 first-year positions and are oversubscribed by graduating medical students.

These trends indicate that the ulitmate enlargement of the pool of primary-care physicians must be nurtured by all professional agencies and institutions having a responsibility for the education of physicians. The educational process takes several years; thus, the initiation of change today will be visible in the delivery of medical services only in the future.

An extensive review by the committee of the subject of FMGs resulted in a report containing 45 recommendations addressed to schools of medicine, teaching hospitals, professional organizations, accrediting agencies, licensing authorities, and several sectors of the federal government. The report has been approved by the CCME and its five parent bodies.

The report points out the lack of coordination of national policies concerning the role of FMGs in the health-care system, the preferential and flexible immigration policies which encourage large numbers of FMGs to emigrate to the United States, the wide range of educational

backgrounds and varying professional competence of FMGs, the inappropriateness of the examination by the Educational Council for Foreign Medical Graduates (ECFMG) to qualify an FMG for entrance to a graduate program, the lack of an effective assessment of the English-language capability of FMGs, the service rather than educational aspects of many residency programs to which FMGs are attracted, the thousands of FMGs who are already in the United States and cannot qualify for licensure, and the difficulty that United States nationals who study medicine abroad have in re-entering the educational system in the United States.

The report has recommendations addressed to 1) the foreign physician who is a temporary visitor, 2) foreign nationals seeking permanent residence, 3) United States nationals studying medicine abroad, and 4) United States assistance to medical education in developing countries.

The principal recommendations are:

1) The original intent of the Exchange Visitors Act of 1948 should be recognized and implemented so that tenure in the United States would not exceed two years and conversion of temporary visas to permanent visas would be discontinued.

2) All FMGs entering the United States should be required either to have a license to practice medicine in one of the licensing jurisdictions of the United States or to qualify for admission to graduate programs by passing an examination required of both FMGs and United States medical graduates alike.

3) A more rigorous assessment of verbal and written ability in the English language should be required.

4) Schools of medicine should assume the sponsorship of exchange visitors and specific educational programs should be devised to meet their needs upon return to their own country.

5) Blanket certification on an occupational basis for preference and nonpreference visas should be discontinued.

6) Eligibility and qualifying procedures for full licensure should be uniform in all states and should apply to FMGs as well as United States medical graduates.

7) The Coordinated Transfer Application System (COTRANS) should be expanded to accommodate more United States nationals studying abroad.

8) Eligibility requirements for entrance into graduate medical programs

for United States nationals studying abroad should be identical with those required of FMGs.

9) The United States should assist developing countries in improving their educational systems to meet their own health-care needs.

Following the development of this report, an invitational conference was held; it was attended by representatives of 25 voluntary medical organizations and several sectors of the federal government. The conference overwhelmingly endorsed the report with some suggested changes which were incorporated into the final version.

The implementation of these recommendations will take time; consideration must be given to the avoidance of abrupt change which could have a deleterious impact upon the delivery of care, especially in municipal hospitals serving inner cities.

The committee on physician distribution and the CCME are developing a report on the specialty and geographic distribution of physicians. This subject is receiving widespread attention by the federal and state governments, specialty organizations in medicine, and many individuals in the medical profession. Their views vary enormously, depending upon their background, their public or private commitments, and their vested interests. Sociologists, economists, and demographers generally take a simplistic numerical view of the problem, whereas the physician practicing 80 hours a week has a different perspective. The issue of specialty and geographic distribution of physicians is incredibly complex; arbitrary or unilateral decisions are more apt to create chaos than to improve the delivery of medical services. Resolving this problem is exceptionally difficult in a democratic society. However, it can be accomplished without central regulation and control.

The basic problem relates to the progressive reduction in the number of primary-care physicians in the United States. This is a sequel to the rapid development following World War II of specialization and almost endless subspecialization and the concomitant disappearance of generalists in medical schools and university hospitals. In this setting the profile of the general practitioner, general internist, and general pediatrician became so remote that students had no model to view when career choices were made. If faculties of medical schools and staffs of university hospitals during this period had foreseen, by some unusual means, the societal problems of the 1970s and had preserved a better balance between specialists and generalists there would be less of a problem today. Medical

schools and university hospitals alone, however, cannot be blamed for present-day problems. National professional organizations in the various specialties were in a period of exuberant growth and were more interested in their identification and professional stature than in the needs of the people. The tremendous support of research by both the private and public sectors of the health industry played a role in the advancement of specialization. Many of us well along in years, including myself, were responsible for the environment of medical education in the 1950s and 1960s. It is to be hoped that adjustments can be made on a voluntary basis. If society's needs, real or alleged, cannot be met by the resolution of problems within the private sector of health care and education, legislation within the public sector is inevitable.

The conclusions that are stated with almost monotonous repetition are that there are not enough primary-care physicians and that there are too many surgeons. The former statement can be documented and the latter is rapidly becoming true as more and more studies of the productivity and professional effort of surgeons are completed.

The recently published volume, *Surgery in the United States*,[6] contains much information about the physician-manpower problem. The geographic distribution of surgeons is excellent, especially in specialties having large numbers of surgeons such as general surgery, orthopedics, and urology. Based upon the mean board-certification rate between 1969 and 1971 and adjusting to population changes, the growth rate of surgical specialists projected for the next several years is in excess of projected needs. The suggestion is made that the number of surgeons completing residencies each year should be reduced from between 2,500 and 3,000 to between 1,600 and 2,000.

There obviously is a growing awareness by all individuals, societies, and institutions of the need for additional primary-care physicians. Changes are occurring with great rapidity and many of these are taking place spontaneously as a result of the social motivations of medical students. If residencies in primary care are defined as those in family practice, internal medicine, and pediatrics, the percentage of graduating students entering these areas has increased from 32.2% in 1968 to 58.6% in 1975. If obstetrics and gynecology is included, the figure in 1975 is 63.7%. This trend almost certainly will continue for some time to come.

The CCME, through its Committee on Physician Distribution, is engaged in analyzing and documenting the specialty and geographic distri-

bution of physicians, determining optimal proportions of physicians of all types for the delivery of comprehensive medical services, studying the controllable and uncontrollable factors which determine career choices and geographic location, analyzing current trends in distribution, determining what changes should be made, and making appropriate recommendations for needed changes. For instance, more than 35 factors influence a physician's choice of career and location. Many of them relate to modes of practice, such as the availability of other specialists, single and multidisciplinary groups, and hospital beds.

The public, as manifested by the absorbing interest of federal and state legislators, is impatient with the medical profession for not resolving the problem of physician manpower more expeditiously. Many have no confidence that the medical profession and its system of medical education will be responsive to societal needs. What often is not appreciated is that significant changes in the number and characteristics of the physician population take a long time; changes in the schools of medicine require time to become visible in the delivery of medical services. The medical schools have responded to professed needs in many ways. In 1970 medical graduates numbered 8,974. In 1975 the number was 12,714. By 1977 it will approximate 15,000. In a democratic society relatively free of federal manipulation this represents a remarkable effort. In 1969 there were no residents in family practice. Today there are 3,720. No matter how impressive these changes are, it will take additional time before the public becomes aware of an increased availability of medical services. The same would be true, however, if change in the educational system was accomplished by arbitrary federal regulation.

None of this should imply that the fragmentation of the medical profession and its lack of cohesive and integrated national policy have not been detrimental to the best interests of both the public and the profession. On careful examination this is all too evident. Change, however, is occurring with greater rapidity than can be observed by casual scrutiny.

A serious problem facing the CCME is determining the methods to be employed in effecting the redistribution of physicians and the agency which should take the responsibility. Some federal legislators feel that the problem deserves urgent resolution and that some arbitrary redistribution should be carried out, with the final responsibility in the hands of the secretary of DHEW. He would be advised by either the CCME or an appointed advisory council.

The CCME feels that the development of appropriate policy by the CCME with endorsement by its five parent organizations would provide the best incentives for professional agencies, physicians, and students to recognize the public's needs and adopt a variety of processes that would ultimately resolve the problem.

The CCME generally looks with disfavor upon any legislation that would place a voluntary professional organization responsible for the development of national policy in a position where it would have a formal and legislated responsibility to the secretary of DHEW. It would become an operating committee with executive authority: this was not the intent of the developers of this committee.

I believe that, with or without legislation—preferably without—the CCME is the logical agency in the medical profession to generate national policy for medical education, recommendations to professional and public agencies, and guidelines for the accreditation process conducted by the liaison committees.

Pressures arising within the legislative branch of the federal government are a real challenge to the medical profession and especially to the CCME. If the legislation that provides for the regulation of residency programs through the secretary of DHEW fails or is vetoed, there should be no reduction in the intensity of effort now being employed by the CCME to resolve societal problems. At stake is the determination of whether voluntary medicine can regulate itself to meet demonstrable needs of the citizenry in the amorphous freedom existing in a democratic society or whether societal controls must be imposed upon the profession to achieve those objectives. If the medical profession—which has exceeded every other profession in the development of continuing education, accreditation, and certification procedures of high quality—cannot rise voluntarily to meet the public challenge, then all professions ultimately will be regulated by centralized agencies in the public sector.

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